4 Professional Remittance Advice Guidelines

4.1 Introduction

4.1.1 General Policy

This section covers all parts of the paper Medicaid remittance advice (RA) issued by the Department of Health and Welfare (DHW) for services offered by Medicaid. It addresses the following:

- Banner page.
- Professional claims.
- Financial items.
- Earnings data.

The paper remittance and status report, or remittance advice (RA), is a computer-generated notice sent to all Medicaid providers who have claims in the Medicaid system. Providers may elect to receive RAs electronically. Please refer to *Section 4.1.2.1 Receiving Electronic RAs*, for information on how to sign up to receive electronic RAs. The paper RA shows providers the status of all their claims based on the system's most recent processing cycle. It also shows the breakdown of payment.

If a provider renders two clearly different types of service, he or she will be issued more than one provider number. If a provider has more than one unique provider number under which they are billing, the provider will receive more than one RA, one for each billing number. The RA is designed to simplify the provider's accounting and allows accurate reconciliation of Medicaid claims.

Remittance advices are produced weekly during the weekly claims cycle. All claims received and keyed into the system appear on the submitting provider's RA. If a claim was received late in the week and not entered into the system before the payment cycle or if the provider number is invalid, it does not appear on the RA.

A remittance advice is created only for providers who have claims or financial activity during the week. Providers must maintain a copy of their RAs for a minimum of five years.

4.1.2 Claim Status

Claims and adjustments will be completely processed in the Medicaid system. If a claim is submitted with multiple lines and some lines are paid and some are denied the claim will be listed in the paid section. The claim is reported in the paid section because the provider received payment for a portion of the claim. The denied lines will have up to ten of the explanation of benefit codes listed at header and up to ten at the detail line, explaining why the detail line denied. All processed or in-process claims are placed into one of five categories within the section:

- Paid claims or claims that have finalized but have no actual reimbursement because other insurance or Medicare reimbursed more than Medicaid allows.
- Denied claims - Claims which payment has been disallowed.
- Pending claims - Claims which must be reviewed and resolved before they reach a paid or denied status. Pended claims will be displayed on the paper RA until resolved. (Pended claims will NOT appear on the electronic remittance advice (ERA).)
- Adjusted claims - Claims where an error in billing or processing was made when the original claim was paid, resulting in an overpayment or underpayment of the claim.
- Remaining balance of previous adjustments - Recoupment of an overpayment of a claim that was greater than the scheduled payment for the provider in the processing cycle, therefore, recoupment of all or part of the overpayment

Additionally, the RA includes sections concerning:

- Financial items - provider financial transactions that are not tied to a particular claim.
- Earnings data - details the amount of money that has been paid to the provider.

Federally Qualified Health Centers (FQHC) can submit Institutional/UB-04, professional, and pharmacy claims under the same provider number. The claim information is listed in the proper claims section and a financial items and earnings section is created for each claim type.

Providers who do not wish to have pending claims printed on their RA may request the removal of that section. This request should be made in writing to EDS provider enrollment.

Send request to:

EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

4.1.2.1 Receiving Electronic RAs

Providers may receive RAs electronically, on paper, or both. The electronic RA is sent in the 835 ANSI X12 format. (Electronic RAs will not contain the banner information or the pending claims information.)

Providers who wish to receive RAs electronically must purchase their own software. Some vendor software may be able to accept the HIPAA formatted ERA. Please check with your software vendor for more information.

Note: The EDS software is only for the submission of claims or for checking eligibility of a participant, and cannot be used to receive ERAs.

For additional information regarding ERAs or to sign up to receive electronic RAs, contact an EDS technical support representative at:

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

Monday through Friday (excluding state holidays) from 8 a.m. - 6 p.m. MT.

4.1.3 Internal Control Number (ICN)

An Internal Control Number (ICN) is a unique number assigned to all claims and identifies the claim on the provider's remittance advice (RA). The ICN is in a RRCCYYJJJBBBSSS format. This is a series of fields which, when read together, identify each specific claim received. The following key explains the ICN:

RR: The medium in which the claim was received: 10 or 11 = paper; 40 = electronic (ECS); 41 = tape crossover; 43 = point of service

CC: The century in which the claim was received

YY: The year in which the claim was received

JJJ: The Julian calendar date on which the claim was received (January 1 is 001; January 2 is 002, etc.)

BBB: The batch number assigned to each group of claims being processed. A range of batch numbers is assigned to each claim type for ease in identifying the claim type without having the actual claim. This can range from 001 - 899

SSS: The sequence of each claim within a batch. This can be from 000 – 999. (The first claim in the batch is 000.)

Example: The ICN 402002328252047 represents that the claim was submitted electronically; it was received on November 24, 2002 (the 328th day of the year 2002); it was the 48th claim in a batch with 252 claims.

4.2 Banner Page For Paper RA or Paper RA

4.2.1 Overview

The RA banner section is the first page of the paper RA report. This page displays messages from DHW regarding policy information and general notices. Up to 20 messages may be displayed per week.

A paper banner page is also created for providers who receive remittance advices only in the electronic format. This page is mailed weekly so all providers receive DHW notices.

4.2.2 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique 7-digit base number (service location is not indicated) of the provider who is receiving the RA.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date of the RA. This date is the Monday following the financial cycle and is equal to the check issue date.
PAGE	The sequence number of this page of the report when compared to the total number of pages for this report.
TEXT	This field provides 15 lines of text for DHW and EDS to display messages to providers.
PROVIDER NAME	This field is the name corresponding to the provider number.
PROVIDER ADDRESS LINE 1	This field corresponds to the 'pay-to-provider', address located on the provider file.
PROVIDER ADDRESS STREET	This field corresponds to the 'pay-to-provider', street address.
PROVIDER ADDRESS CITY	This field corresponds to the 'pay-to-provider', city.
PROVIDER ADDRESS STATE	This field corresponds to the 'pay-to-provider', state.
PROVIDER ADDRESS ZIP CODE	This field corresponds to the 'pay-to-provider', zip code.

4.2.3 Paper RA Banner Page Example

PROV	0012355	NPI	9988776655	IDAHO MEDICAID REMITTANCE ADVICE		RA NUMBER	4378564854
SEQ NO:	1			RA DATE 11/26/2007		PAGE	1

THIS PAGE DISPLAYS IMPORTANT MESSAGES SUCH AS RECENT POLICY UPDATES, BILLING CHANGES AND HOLIDAY SCHEDULES FOR DHW AND EDS. PLEASE READ THIS INFORMATION AND RETAIN FOR FUTURER REFERENCE. THIS INFORMATION MAY BE DISPLAYED FOR ALL PROVIDERS OR FOR A SPECIFIC PROVIDER TYPE.

OLIVER FAMILY PRACTICE CLINIC
9945 E. OLIVER
STE 445
BOISE, ID 93705-6745

4.3 Professional Paid Claim Paper RAs

4.3.1 Overview

The remittance advice professional paid claim section contains paid claim information for professional paid claims submitted on the CMS-1500 or submitted electronically. Up to ten Explanation of Benefit (EOB) codes (six ARC codes on the ERA) may be listed for each claim header and detail.

The paid claims in this section are grouped together by provider service location. Each service location has a separate section. For more information on service locations, see *Section 1.1.3.2 Multiple Service Locations*. Within provider service location, the claims are grouped by claim type and sorted by participant last name. For each service location subtotals are calculated for each claim type and a grand total is calculated for all claim types.

4.3.2 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of two parts. The first 7-digits are the actual unique number assigned to a provider. The last 2-digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last 2-digits, and the second location will have 01 as the last 2-digits.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated (*e.g.* Professional).
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLAIM TYPE	This field indicates the claim type description for claims located in this section of the RA.
CLIENT NAME	This group of two fields indicates the first five characters of the participant's last name and the first three characters of the participant's first name.
MID	This field indicates the participant's unique Medicaid identification (MID) number as it appears on the claim.
NPI	National Provider Identifier
ICN	This field indicates the unique Internal Control Number (ICN) assigned to the claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX#	This field indicates the participant account number that appears on the claim. The prescription number is not applicable for professional claims.
MED REC #	Medical Record Number as it appears on claim.
HEADER MESSAGES	These ten fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.
FDOS	This field indicates the first date the service was rendered as it appears on the claim.
TDOS	This field indicates the last date the service was rendered as it appears on the claim.
PROC + MODS	These fields indicate the procedure code and corresponding modifiers as they appear on the claim. Up to four modifiers may be displayed.
QTY BLD	This field indicates the units of service as billed on the claim.
BILLED AMT	This field indicates the amount billed by the provider for service.
NON ALLOWED AMT	This field indicates the non-allowed amount for the claim. It is equal to the billed amount minus the allowed amount.
ALLOWED AMT	This field indicates the Medicaid allowed payment for the claim.
INS AMT	This field indicates the amount paid by another insurance carrier for this claim or detail line of a claim.

Field	Description
COPAY AMT	This field indicates the portion of the billed amount for which the participant is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	This field indicates the dollar amount included in the payment for the claim. The value is calculated as: Allowed amount - Co-pay - Third party insurance payment Paid amount
SVC LN #	Tracking number used on professional remittance advice.
CLIENT CONT AMT	This field indicates the participant contribution dollar amount.
DETAIL MESSAGES	These ten fields relate to the message codes printed under the detail information. These numbers are EOB codes and indicate the reasons for payment or denial for the claim on the detail level (lower portion of the claim).
CLAIM TOTALS BILLED AMT	This field indicates the total amount billed for the claim. This value is equal to the sum of the detail billed amounts for the claim.
CLAIM TOTALS NON ALLOWED AMT	This field indicates the total non-allowed amount for the claim. This value is equal to the sum of the detail non-allowed amounts for the claim.
CLAIM TOTALS ALLOWED AMT	This field indicates the total payment allowed for the claim. This value is equal to the sum of the detail allowed amount for the claim.
CLAIM TOTALS INS AMT	This field indicates the total amount paid by other insurance for the claim. This value is equal to the sum of the detail other insurance amounts for the claim.
CLAIM TOTALS COPAY AMT	This field indicates the total co-pay amount for the claim. This value is equal to the sum of the detail co-pay amounts for the claim. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
CLAIM TOTALS PAID AMT	This field indicates the total amount paid for the claim. This value is equal to the sum of the detail paid amounts for the claim.
CLAIM TOTALS CLIENT CONT AMT	This field indicates the total participant contribution dollar amount for the claim.
TOTALS FOR CLAIM TYPE DESCRIPTION	This field indicates the claim type description associated with the following totals.
TOTALS FOR CLAIM TYPE	This field indicates the total number of claims under the claim type appearing in this section of the RA.
TOTALS FOR CLAIM TYPE BILLED AMT	This field indicates the sum of all billed amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the billed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE NON ALLOWED AMT	This field indicates the sum of all non-allowed amounts the claim type appearing in this section of the RA. This value is equal to the sum of the non-allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE ALLOWED AMT	This field indicates the sum of all allowed payment amounts for claims appearing in this section of the RA. This value is equal to the sum of the allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE INS AMT	This field indicates the sum of all insurance amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the other insurance amounts appearing on the header level.
TOTALS FOR CLAIM TYPE COPAY AMT	This field indicates the sum of all co-pay amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the co-pay amounts appearing on the detail level. Currently not applicable in Idaho. This field is always 0.00.
TOTALS FOR CLAIM TYPE PAID AMT	This field indicates the sum of all paid amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the paid amounts appearing on the detail level. The value is calculated as: CLAIM TOTALS ALLOWED AMOUNT -CLAIM TOTALS COPAY AMOUNT -CLAIM TOTALS INSURANCE AMOUNT CLAIM TOTALS PAID AMOUNT

Field	Description
TOTALS FOR CLAIM TYPE CLIENT CONT AMT	This field indicates the participant contribution amount for this claim type.
PAID CLAIMS TOTALS	This field indicates the total number of paid claims appearing in the claims section of the RA. This value is equal to the sum of the claim type subtotals in the paid claims section of the RA.
PAID CLAIMS TOTALS BILLED AMT	This field indicates the total billed amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type billed amount subtotals in the paid section of the RA.
PAID CLAIMS TOTALS NON ALLOWED AMT	This field indicates the total non-allowed amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type non-allowed amount subtotals in the paid section of the RA.
PAID CLAIMS TOTALS ALLOWED AMT	This field indicates the total allowed payment amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type allowed payment subtotals in the paid section of the RA.
PAID CLAIMS TOTALS INS AMT	This field indicates the total other insurance amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type other insurance amount subtotals in the paid section of the RA.
PAID CLAIMS TOTALS COPAY AMT	This field indicates the total co-pay amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type co-pay amount subtotals in the paid section of the RA. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID CLAIMS TOTALS PAID AMT	This field indicates the total paid amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type paid amount subtotals in the paid section of the RA.
PAID CLAIMS TOTALS CLIENT CONT AMT	This field indicates the participant contribution dollar amount for all paid professional claims.

4.3.3 Professional Paid Claims Paper RA Example

PROV 0487566502 NPI 9988776655 IDAHO MEDICAID REMITTANCE ADVICE RA NUMBER 8875455978
SEQ NO: 1 PROFESSIONAL PAGE NUM: 2
RA DATE 11/26/2007

CLIENT NAME MID NPI ICN HVER PT ACCT/RX # MED REC#
HEADER MESSAGES
DNUM FDOS TDOS PROC + MODS QTY BLD BILLED AMT NON-ALLOWED AMT ALLOWED AMT INS AMOUNT COPAY AMT PAID AMT
SVC LN # CLIENT CONT AMT
DETAILS MESSAGES

PAID CLAIMS:

CLAIM TYPE: PHYSICIAN

DURAN JOE 06575480000 9988776655 112007160050010 00 05545878
365
01 06/06/07 06/06/07 99381 1 59.00 6.57 52.43 28.60 0.00 23.83
365 0.00
02 06/06/07 06/06/07 0100J 3 15.00 6.00 9.00 0.00 0.00 9.00
0.00

CLAIMS TOTALS: 74.00 12.57 61.43 28.60 0.00 32.83
0.00
TOTALS FOR CLAIM TYPE: PHYSICIAN 1 CLAIM(S) 74.00 12.57 61.43 28.60 0.00 32.83
0.00
PAID CLAIMS TOTALS: 1 CLAIM(S) 74.00 12.57 61.43 28.60 0.00 32.83
0.00

4.4 Professional Denied Claim Paper RA

4.4.1 Overview

The professional denied claim section of the RA contains denied claim information for professional denied claims. The Explanation of Benefit (EOB) codes listed on the RA explain why the claim or a claim was denied. The RA displays up to ten EOB messages (six ARC codes on the ERA) for each header (upper portion of the claim) and detail (lower portion of the claim). All third party recovery (TPR) information on file is displayed immediately following any claim denied for TPR-related reasons. Providers should bill the indicated insurance carrier using the information displayed.

The denied claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the claims are grouped by claim type and sorted by participant last name. For each service location subtotals are calculated for each claim type and a grand total is calculated for all claim types.

4.4.2 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of two parts. The first 7-digits are the actual unique number assigned to a provider. The last 2-digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last 2-digits, and the second location will have 01 as the last 2-digits.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated (*e.g.* Professional).
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLAIM TYPE	This field indicates the claim type description for claims located in this section of the RA.
CLIENT NAME	This group of two fields indicates the first five characters of the participant's last name and the first three characters of the participant's first name.
MID	This field indicates the participant's unique Medicaid identification (MID) number as it appears on the claim.
NPI	National Provider Identifier
ICN	This field indicates the unique Internal Control Number (ICN) assigned to the claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX#	This field indicates the participant account or medical record number that appears on the claim. The prescription number is not applicable for professional claims.
MED REC #	Medical Record Number as it appears on claim.
HEADER MESSAGES	These ten fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for denial of the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.
FDOS	This field indicates the first date the service was rendered as it appears on the claim.
TDOS	This field indicates the last date the service was rendered as it appears on the claim.
PROC + MODS	These fields indicate the procedure code and corresponding modifiers as they appear on the claim. Up to four modifiers may be displayed.
QTY BLD	This field indicates the units of service as billed on the claim.
BILLED AMT	This field indicates the amount billed by the provider for the claim.
NON ALLOWED AMT	This field indicates the claim's non-allowed amount. It is equal to the billed amount minus the allowed amount.
ALLOWED AMT	This field indicates the Medicaid allowed payment for the claim detail.

Field	Description
INS AMT	This field indicates the amount paid by another insurance carrier for this claim detail.
COPAY AMT	This field indicates the portion of the detail billed amount for which the participant is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	This field indicates the dollar amount included in the payment for the claim.
SVC LN #	Tracking number used on professional remittance advice.
CLIENT CONT AMT	This field indicates the participant contribution amount
DETAIL MESSAGES	These ten fields relate to the message codes printed under the detail information. These numbers are EOB codes and indicate the reasons for denial of the claim on the detail level (lower portion of the claim).
MEDICARE	This field indicates the Medicare type. Possible values are Part A or Part B. If the claim is for outpatient services than Part B will be listed. If inpatient services are being rendered Part A will be indicated in this field.
MEDICARE ID	This field indicates the Medicare ID number of the participant if the provider is to bill Medicare for the services rendered on the claim.
CARRIER NAME	This field indicates the name of the insurance carrier with whom the participant has Medicare coverage. If the participant has multiple insurance policies on file that cover the services rendered, all will be listed.
CARR CODE	This field indicates the unique code assigned to the insurance carrier.
CARRIER NAME	This field indicates the name of the insurance carrier with whom the participant has other insurance coverage.
STREET LINE 1	This field indicates the first line of the insurance carriers street address located on the insurance carrier file for the carrier code.
STREET LINE 2	This field indicates the second line of the insurance carriers street address located on the insurance carrier file for the carrier code.
CITY	This field corresponds to the city located on the insurance carrier file for the carrier code for the carrier code.
STATE	This field corresponds to the state located on the insurance carrier file for the carrier code.
ZIP CODE	This field corresponds to the zip code located on the insurance carrier file for the carrier code.
SUBSCRIBER NAME	This field indicates the name of the person who is the insurance policy subscriber.
SUBSCRIBER SSN	This field indicates the Social Security number of the person who is the insurance policy subscriber.
POLICY NUMBER	This field indicates the policy number of the insurance the participant holds with the insurance carrier.
GROUP	This field indicates the group number associated with the insurance policy.
CLAIM TOTALS BILLED AMT	This field indicates the total amount billed for the claim. This value is equal to the sum of the detail billed amounts for the claim.
CLAIM TOTALS NON ALLOWED AMT	This field indicates the total amount non-allowed for the claim. This value is equal to the sum of the detail non-allowed amounts for the claim.
CLAIM TOTALS ALLOWED AMT	This field indicates the total amount allowed for the claim. This value is equal to the sum of the detail allowed amounts for the claim.
CLAIM TOTALS INS AMT	This field indicates the total amount paid by other insurance for the claim. This value is equal to the sum of the detail other insurance amounts for the claim.
CLAIM TOTALS COPAY AMT	This field indicates the total co-pay amount for the claim. This value is equal to the sum of the detail co-pay amounts for the claim. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
CLAIM TOTALS	This field indicates the total amount paid for the claim. This value is equal to the sum of the detail co-pay amounts for the claim.
CLAIM TOTALS CLIENT CONT AMT	This field indicates the participant contribution dollar amounts for the claim.
TOTALS FOR CLAIM TYPE DESCRIPTION	This field indicates the claim type description associated with the claims located in this section of the RA.
TOTALS FOR CLAIM TYPE	This field indicates the total number of claim for the claim type appearing in this section of the provider's RA.

Field	Description
TOTALS FOR CLAIM TYPE BILLED AMT	This field indicates the sum of all billed amounts for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the billed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE NON ALLOWED AMT	This field indicates the sum of all non-allowed amount for the claim type appearing in this section of the provider's RA. This value is equal to the sum of the non-allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE ALLOWED AMT	This field indicates the sum of all allowed payment amounts for claims appearing in this section of the RA. This value is equal to the sum of the allowed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE INS AMT	This field indicates the sum of all insurance amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the other insurance amounts appearing on the header level.
TOTALS FOR CLAIM TYPE COPAY AMT	This field indicates the sum of all co-pay amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the co-pay amounts appearing on the detail level. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
TOTALS FOR CLAIM TYPE PAID AMT	This field indicates the sum of all paid amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the paid amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE CLIENT CONT AMT	This field indicates the participant contribution amount for this claim type.
DENIED CLAIMS TOTALS	This field indicates the total number of paid claims appearing in the claims section of the RA. This value is equal to the sum of the claim type subtotals in the paid claims section of the RA.
DENIED CLAIMS TOTALS BILLED AMT	This field indicates the total billed amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type billed amount subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS NON ALLOWED AMT	This field indicates the total non-allowed amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type non-allowed amount subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS ALLOWED AMT	This field indicates the total allowed payment amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type allowed payment subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS INS AMT	This field indicates the total other insurance amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type other insurance amount subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS COPAY AMT	This field indicates the total co-pay amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type co-pay amount subtotals in the denied section of the RA. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
DENIED CLAIMS TOTALS PAID AMT	This field indicates the total paid amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type paid amount subtotals in the denied section of the RA.
DENIED CLAIMS TOTALS CLIENT CONT AMT	This field indicates the participant contribution dollar amount for all denied professional claims.

4.4.3 Professional Denied Claims Paper RA Example

PROV 0005876600 NPI 9988776655 IDAHO MEDICAID REMITTANCE ADVICE RA NUMBER 8789566444
SEQ NO: 1 PROFESSIONAL PAGE NUM: 3
RA DATE 11/26/2007

CLIENT NAME MID NPI ICN HVER PT ACCT/RX # MED REC#
HEADER MESSAGES
DNUM FDOS TDOS PROC + MODS QTY BLD BILLED AMT NON-ALLOWED AMT ALLOWED AMT INS AMOUNT COPAY AMT PAID AMT
SVC LN # AMT CLIENT CONT AMT
DETAILS MESSAGES

DENIED CLAIMS:

CLAIM TYPE: TRANSPORTATION

HOLLI DAI 05448120000 9988776655 112007164248000 00 03358790
399
01 05/15/07 05/15/07 0094A 221 46.41 46.41 0.00 0.00 0.00 0.00
399 0.00
CLAIM TOTALS: 46.41 46.41 0.00 0.00 0.00
0.00

MEDICARE: PART A MEDICARE ID: 222222222 CARRIER NAME: MEDICARE PART A
CARR CODE: MEDA MEDICARE
5555 HAPPY VALLEY ROAD BOISE ID 83705-4591
SUBSCRIBER NAME: GRP INS MEDICARE SUBSCRIBER SSN: 222222222 POLICY: 222222222A GROUP: 01
TOTALS FOR CLAIM TYPE: TRANSPORTATION 1 CLAIM(S) 46.41 46.41 0.00 0.00 0.00 0.00
0.00
DENIED CLAIMS TOTALS: 1 CLAIM(S) 46.41 46.41 0.00 0.00 0.00 0.00
0.00

4.5 Professional Pending Claim Paper RAs

4.5.1 Overview

The professional pended claims RA section contains pended claim information for professional pended claims and adjustments. Up to ten Explanation of Benefit (EOB) codes may be listed for each claim header and detail. The EOB codes indicated for pended claims are general in nature and do not address specific problems with the claims. Only the billed amount field will be displayed on the RA. All other amount fields will be blank.

The pended claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the claims are grouped by claim type and sorted by participant last name. For each service location subtotals are calculated for each claim type and a grand total is calculated for all claim types.

Note: Pending claims will not appear on the electronic remittance advice (ERA).

4.5.2 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of two parts. The first 7-digits are the actual unique number assigned to a provider. The last 2-digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last 2-digits, and the second location will have 01 as the last 2-digits.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated *e.g.* Professional).
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLAIM TYPE	This field indicates the claim type description for claims located in this section of the RA.
CLIENT NAME	This group of two fields indicates the first five characters of the participant's last name and the first three characters of the participant's first name.
MID	This field indicates the participant's unique Medicaid identification (MID) number as it appears on the claim.
NPI	National Provider Identifier
ICN	This field indicates the unique Internal Control Number (ICN) assigned to the claim.
HVER	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent version numbers are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX #	This field indicates the participant account or medical record number that appears on the claim. The prescription number is not applicable for professional claims.
MED REC #	Medical Record Number as it appears on claim.
HEADER MESSAGES	These 10 fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for pending the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.
FDOS	This field indicates the first date the service was rendered as it appears on the claim.
TDOS	This field indicates the last date the service was rendered as it appears on the claim.
PROC + MODS	These fields indicate the procedure code and corresponding modifiers as they appear on the claim. Up to four modifiers may be displayed.
QTY BLD	This field indicates the units of service as billed on the claim.
BILLED AMT	This field indicates the amount billed by the provider for service.
NON ALLOWED AMT	This field is always blank for pending claims.

Field	Description
ALLOWED AMT	This field is always blank for pending claims.
INS AMT	This field is always blank for pending claims.
COPAY AMT	This field is always blank for pending claims. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	This field is always blank for pending claims.
SVC LN #	Tracking number used on professional remittance advice.
CLIENT CONT AMT	This field is always blank for pending claims.
DETAIL MESSAGES	These ten fields relate to the message codes printed under the detail information. These numbers are EOB codes and indicate the reasons the claim pended.
CLAIM TOTALS BILLED AMT	This field indicates the total dollar amount billed for the claim. This value is equal to the sum of the detail billed amounts for the claim.
CLAIM TOTALS NON ALLOWED AMT	This field is always blank for pending claims.
CLAIM TOTALS ALLOWED AMT	This field is always blank for pending claims.
CLAIM TOTALS INS AMT	This field is always blank for pending claims.
CLAIM TOTALS COPAY AMT	This field is always blank for pending claims.
CLAIM TOTALS PAID AMT	This field is always blank for pending claims.
CLAIM TOTALS CLIENT CONT AMT	This field is always blank for pending claims.
TOTALS FOR CLAIM TYPE DESCRIPTION	This field indicates the claim type description for claims in this section of the RA.
TOTALS FOR CLAIM TYPE	This field indicates the total number of claims appearing in this section of the RA.
TOTALS FOR CLAIM TYPE BILLED AMT	This field indicates the sum of all billed amounts for the claim type appearing in this section of the RA. This value is equal to the sum of the billed amounts appearing on the detail level.
TOTALS FOR CLAIM TYPE NON ALLOWED AMT	This field is always blank for pending claims.
TOTALS FOR CLAIM TYPE ALLOWED AMT	This field is always blank for pending claims.
TOTALS FOR CLAIM TYPE INS AMT	This field is always blank for pending claims.
TOTALS FOR CLAIM TYPE COPAY AMT	This field is always blank for pending claims.
TOTALS FOR CLAIM TYPE PAID AMT	This field is always blank for pending claims.
TOTALS FOR CLAIM TYPE CLIENT CONT AMT	This field is always blank for pending claims.
PENDING CLAIMS TOTALS	This field indicates the total number of claims appearing in the claims section of the RA. This value is equal to the sum of the claim type subtotals in the pending claims section of the RA.
PENDING CLAIMS TOTALS BILLED AMT	This field indicates the total billed amount appearing in the paid claims section of the RA. This value is equal to the sum of the claim type billed amount subtotals in the pending section of the RA.

Field	Description
PENDING CLAIMS TOTALS NON ALLOWED AMT	This field is always blank for pending claims.
PENDING CLAIMS TOTALS ALLOWED AMT	This field is always blank for pending claims.
PENDING CLAIMS TOTALS INS AMT	This field is always blank for pending claims.
PENDING CLAIMS TOTALS COPAY AMT	This field is always blank for pending claims.
PENDING CLAIMS TOTALS PAID AMT	This field is always blank for pending claims.
PENDING CLAIMS TOTALS CLIENT CONT AMT	This field is always blank for pending claims.

4.5.3 Professional Pending Claims Paper RA Example

PROV 100112500 NPI 9988776655 IDAHO MEDICAID REMITTANCE ADVICE RA NUMBER 2215935645
SEQ NO: 1 PROFESSIONAL PAGE NUM: 4
RA DATE 11/26/2007

CLIENT NAME MID NPI ICN HVER PT ACCT/RX # MED REC#
HEADER MESSAGES
DNUM FDOS TDOS PROC + MODS QTY BLD BILLED AMT NON-ALLOWED AMT ALLOWED AMT INS AMOUNT COPAY AMT PAID AMT
SVC LN # CLIENT CONT AMT
DETAILS MESSAGES

PENDING CLAIMS DO NOT REBILL

CLAIM TYPE: PERSONAL CARE

ALEXA RAN 05557860000 9988776655 402007174248011 00
999 999 999 999 999 999 999 999 999 999 999 999
01 06/15/07 06/15/07 0542P 16 31.68
999 999 999 999 999 999 999 999 999 999 999 999 999 999 999

CLAIM TOTALS: 31.68

TOTALS FOR CLAIM TYPE: PERSONAL CARE 1 CLAIM(S) 31.68

PENDING CLAIMS TOTALS: 1 CLAIM(S) 31.68

CLAIMS TOTALS: 74.00 12.57 61.43 28.60 0.00 32.83

4.6 Professional Adjusted Claim Paper RAs

4.6.1 Overview

The professional adjusted claim RA section contains adjusted claim information for professional adjusted claims. Up to ten Explanation of Benefit (EOB) codes (six ARC codes on the ERA) may be listed for each claim header and detail. On the paper RA for each adjusted claim, the RA first displays the original claim payment information then displays the adjusted claim payment information immediately following the original. The original paid amount, current new paid amount, refund from provider amount, net adjustment amount and a description of the adjustment reason code is included after each adjusted claim. If the net adjustment amount is a negative amount the number will be printed with a minus sign (-). On the electronic remittance advice (ERA) this grouping will not occur.

Claim voids and claim replacements (electronic equivalent of the paper adjustment process) will occur in their own sections. Adjustments may be initiated by 1) providers to correct claims submission or processing errors, or 2) by EDS to recoup incorrect payments. DHW may initiate adjustments for recoupments or retroactive rate adjustments.

The adjusted claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the adjusted claims are sorted by participant last name. Grand totals are calculated for adjustment claim totals and a total net adjustment amount is calculated to reflect the net effect of all adjustments.

4.6.2 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of two parts. The first 7-digits are the actual unique number assigned to a provider. The last 2-digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last 2-digits, and the second location will have 01 as the last 2-digits.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated (*e.g.* Professional).
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLIENT NAME ORIGINAL CLAIM	This group of two fields indicates the first five characters of the participant's last name and the first three characters of the participant's first name as it appears on the original claim.
MID ORIGINAL CLAIM	This field indicates the participant's unique Medicaid identification (MID) number as it appears on the original claim.
NPI ORIGINAL CLAIM	National Provider Identifier
ICN ORIGINAL CLAIM	This field indicates the unique Internal Control Number (ICN) assigned to the claim.
HVER ORIGINAL CLAIM	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent versions are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX# ORIGINAL CLAIM	This field indicates the participant account or medical record number that appears on the original claim. The prescription number is not applicable for professional claims.
MED REC #	Medical Record Number as it appears on claim.
HEADER MESSAGES ORIGINAL CLAIM	These ten fields relate to the message codes printed under the header information for the original claim. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.

Field	Description
FDOS ORIGINAL CLAIM	This field indicates the first date the service was rendered as it appears on the claim.
TDOS ORIGINAL CLAIM	This field indicates the last date the service was rendered as it appears on the claim.
PROC + MODS ORIGINAL CLAIM	These fields indicate the procedure code and corresponding modifiers billed by the provider for treatment of the participant. Up to four modifiers may be displayed. This value corresponds with the procedure code appearing on the original claim.
QTY BLD ORIGINAL CLAIM	This field indicates the units of service as billed on the original claim.
BILLED AMT ORIGINAL CLAIM	This field indicates the amount billed on the original claim by the provider for service.
NON ALLOWED AMT ORIGINAL CLAIM	This field indicates the non-allowed amount for the original claim.
ALLOWED AMT ORIGINAL CLAIM	This field indicates the Medicaid allowed payment for the original claim.
INS AMT ORIGINAL CLAIM	This field indicates the amount paid by another insurance carrier for the original claim or detail.
COPAY AMT ORIGINAL CLAIM	This field indicates the original portion of the billed amount for which the participant is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT ORIGINAL CLAIM	This field indicates the dollar amount originally paid.
SVC LN #	Tracking number used on professional remittance advice.
CLIENT CONT AMT ORIGINAL CLAIM	This field indicates the participant contribution amount.
DETAIL MESSAGES ORIGINAL CLAIM	These ten fields relate to the message codes printed under the header information for the original claim. The messages may be different for each detail. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
ORIGINAL CLAIM TOTALS BILLED AMT	This field indicates the total amount billed for the claim. This value is equal to the sum of the detail billed amounts for the claim.
ORIGINAL CLAIM TOTALS NON ALLOWED AMT	This field indicates the total non-allowed amount for the claim. This value is equal to the sum of the detail non-allowed amounts for the claim.
ORIGINAL CLAIM TOTALS ALLOWED AMT	This field indicates the total payment allowed for the claim. This value is equal to the sum of the detail allowed amount for the claim.
ORIGINAL CLAIM TOTALS INS AMT	This field indicates the total amount paid by other insurance for the claim. This value is equal to the sum of the detail other insurance amounts for the claim.
ORIGINAL CLAIM TOTALS COPAY AMT	This field indicates the total co-pay amount for the claim. This value is equal to the sum of the detail co-pay amounts for the claim. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
ORIGINAL CLAIM TOTALS PAID AMT	This field indicates the total amount paid for the claim. This value is equal to the sum of the detail paid amounts for the claim.
PAID DATE ORIGINAL CLAIM	This field indicates the date when the original claim was paid.
CLIENT NAME ADJUSTED CLAIM	This group of two fields indicates the first five characters of the participant's last name and the first three characters of the participant's first name appearing on the adjusted claim.
MID ADJUSTED CLAIM	This field indicates the participant's unique Medicaid identification (MID) number as it appears on the adjusted claim.
NPI	National Provider Identifier
ICN	This field indicates the unique Internal Control Number (ICN) assigned to the claim.
HVER ADJUSTED CLAIM	The header version number corresponds to the ICN and indicates the version of the claim. If the adjustment was made at the header level, the header version number is incremented. If the adjustment was made at the detail level, the header version number is not incremented.

Field	Description
PT ACCT/RX # ADJUSTED CLAIM	This field indicates the participant account or medical record number that appears on the adjusted claim. The prescription number is not applicable for professional claims.
MED REC # Adjusted ACCT/RX #	Medical Record Number as it appears on claim.
HEADER MESSAGES ADJUSTED CLAIM	These ten fields relate to the message codes printed under the header information. These numbers are Adjustment Reason codes and indicate the reasons for adjustment of the claim.
DNUM ADJUSTED CLAIM	The detail number corresponds to the ICN and indicates the detail of the claim.
FDOS ADJUSTED CLAIM	This field indicates the first date the service was rendered as it appears on the claim.
TDOS ADJUSTED CLAIM	This field indicates the last date the service was rendered as it appears on the claim.
PROC + MODS ADJUSTED CLAIM	These fields indicate the procedure code and corresponding modifiers billed by the provider for treatment of the participant. Up to four modifiers may be displayed. This value corresponds with the procedure code appearing on the adjusted claim.
BILLED AMT ADJUSTED CLAIM	This field indicates the adjusted claim amount billed by the provider for service.
NON ALLOWED AMT ADJUSTED CLAIM	This field indicates the non-allowed amount for the adjusted claim.
ALLOWED AMT ADJUSTED CLAIM	This field indicates the Medicaid allowed payment for the adjusted claim.
INS AMT ADJUSTED CLAIM	This field indicates the amount paid by another insurance carrier for the adjusted claim or detail.
COPAY AMT ADJUSTED CLAIM	This field indicates the adjusted portion of the billed amount for which the participant is responsible. Currently not applicable in Idaho. This field is always 0.00.
PAID AMT ADJUSTED CLAIM	This field indicates the dollar amount included in the payment for the adjusted claim.
CLIENT CONT AMT ADJUSTED CLAIM	This field indicates the participant contribution amount for the adjusted claim detail.
DETAIL MESSAGES ADJUSTED CLAIM	These ten fields relate to the message codes printed under the header information and may be different for each detail. These numbers are Adjustment Reason codes and indicate the reasons for adjustment of the claim.
ADJUSTED CLAIM TOTALS BILLED AMT	This field indicates the total amount on adjusted claim billed by the provider for service. This is the sum of all the detail billed amounts for the claim.
ADJUSTED CLAIM TOTALS NON ALLOWED AMT	This field indicates the total non-allowed amount for the adjusted claim. This is the sum of all the detail non-allowed amounts for the claim.
ADJUSTED CLAIM TOTALS ALLOWED AMT	This field indicates the Medicaid allowed payment for the adjusted claim. This is the sum of all the detail allowed amounts for the claim.
ADJUSTED CLAIM TOTALS INS AMT	This field indicates the amount paid by another insurance carrier for the adjusted claim or detail. This is the sum of all the detail other insurance amounts for the claim.
ADJUSTED CLAIM TOTALS COPAY AMT	This field indicates portion of the total billed amount for which the participant is responsible. This is the sum of all the detail co-pay amounts for the claim. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
ADJUSTED CLAIM TOTALS PAID AMT	This field indicates the total included in the payment for the adjusted claim. This is the sum of all the detail paid amounts for the claim.
ADJUSTED CLAIM TOTALS CLIENT CONT AMT	This field indicates the total participant contribution amount for the adjusted claim detail. This is the sum of all the detail participant contribution amounts for the claim.
ADJUSTMENT REASON	This text field explains why the adjustment took place.

Field	Description
ORIGINAL PAID AMT	This text field explains why the adjustment took place.
CURRENT NEW PAID AMT	This field indicates the dollar amount to be paid to the provider for the adjusted claim.
REFUND FROM PROVIDER	This field indicates the dollar amount of refunds the provider has submitted for the adjusted claim.
NET ADJUSTMENT AMOUNT	This field indicates the net effect the adjustment had on the provider. The value is calculated as follows: CURRENT NEW PAID AMOUNT - ORIGINAL PAID AMOUNT + REFUND FROM PROVIDER NET ADJUSTMENT AMOUNT
ADJUSTMENT CLAIM TOTALS	This field indicates the total number of claims appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the adjusted claims and does not count the original claims.
ADJUSTMENT CLAIM TOTALS BILLED AMT	This field indicates the total billed amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the billed amounts for the adjusted claims and does not count values for the original claims.
ADJUSTMENT CLAIM TOTALS NON ALLOWED AMT	This field indicates the total non-allowed amount of the adjusted claims co-pay amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the non-allowed amounts for the adjusted claims and does not count values for the original claims.
ADJUSTMENT CLAIM TOTALS ALLOWED AMT	This field indicates the total allowed amount of the adjusted claims participant credit amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the allowed amounts for the adjusted claims and does not count values for the original claims.
ADJUSTMENT CLAIM TOTALS INS AMT	This field indicates the total insurance amount of the adjusted claims participant credit amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the insurance amounts for the adjusted claims and does not count values for the original claims.
ADJUSTMENT CLAIM TOTALS COPAY AMT	This field indicates the total co-pay amount of the adjusted claims participant credit amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the co-pay amounts for the adjusted claims and does not count values for the original claims. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
ADJUSTMENT CLAIM TOTALS PAID AMT	This field indicates the total paid amount of the adjusted claims participant credit amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the paid amounts for the adjusted claims and does not count values for the original claims.
ADJUSTMENT CLAIM TOTALS CLIENT CONT AMT	This field indicates the total dollar amount of the adjusted claims participant contribution amount appearing in the adjusted claims section of the provider's RA. This value is equal to the sum of the participant contribution amounts for the adjusted claims and does not count values for the original claims.
TOTAL NET ADJUSTMENT AMOUNT	This field indicates the net effect of all adjustments for the provider. The value is equal to the sum of the Net Adjustment Amounts for all adjustments.

4.6.3 Professional Adjusted Claims Paper RA Example

PROV 000108800 NPI 9988776655 IDAHO MEDICAID REMITTANCE ADVICE RA NUMBER 3335458216
SEQ NO: 1 PROFESSIONAL PAGE NUM: 5
RA DATE 11/26/2007

CLIENT NAME MID NPI ICN HVER PT ACCT/RX # MED REC#
HEADER MESSAGES
DNUM FDOS TDOS PROC + MODS QTY BLD BILLED AMT NON-ALLOWED AMT ALLOWED AMT INS AMOUNT COPAY AMT PAID AMT
SVC LN # AMT CLIENT CONT AMT
DETAILS MESSAGES

ADJUSTED CLAIMS

WASHI GEO 7654321 9988776655 402007036222049 00 00111222
111
01 02/03/07 02/04/07 0541P 64 173.44 0.00 173.44 0.00 0.00 173.44
0.00
ORIGINAL CLAIM TOTALS: 173.44 0.00 173.44 0.00 0.00 173.44
0.00
ORIGINAL CLAIM – PAID DATE: 02/10/07
WASHI GEO 7654321 9988776655 532007148231050 01 00111222
111
01 02/03/07 02/04/07 0541P 40 108.40 0.00 108.40 0.00 0.00 108.40
0.00
ADJUSTED CLAIM TOTALS: 108.40 0.00 108.40 0.00 0.00 108.40
0.00
ADJUSTMENT REASON: WRONG UNITS OF SERVICE
ORIGINAL PAID AMT: 173.44 CURRENT NEW PAID AMT: 108.40 REFUND FROM PROV: 65.04 NET ADJUSTMENT AMT: 0.00

ADJUSTMENT CLAIMS TOTALS: 1 CLAIM(S) 108.40 0.00 108.40 0.00 0.00 108.40
0.00
TOTAL NET ADJUSTMENT AMOUNT: 0.00

4.7 Professional Previously Adjusted Claim Paper RAs

4.7.1 Overview

The professional previously adjusted RA claim section contains adjusted claim information for professional adjusted claims. Up to ten Explanation of Benefit (EOB) codes (six ARC codes on the ERA) may be listed for each claim header and detail. This section only shows unsatisfied adjustments that were carried over from the previous financial cycle. An unsatisfied adjustment could occur if, for example, an adjustment on a previous cycle resulted in the provider owing $100.00 to DHW. On the next RA, this adjustment would appear in the previously adjusted claim section of the RA. The $100.00 amount would be indicated in the outstanding balance field.

For each previously adjusted claim, the RA displays the adjusted claim payment information along with the previous balance, any moneys applied to the balance, and the remaining balance. If the remaining balance amount is a negative amount the number will be printed with a minus sign (-).

The previously adjusted claims in this section are grouped together by provider service location. Each service location has a separate section. Within provider service location, the previously adjusted claims are sorted by participant last name. A total remaining balance is calculated to reflect the remaining balance of all adjustments.

4.7.2 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of two parts. The first 7-digits are the actual unique number assigned to a provider. The last 2-digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last 2-digits, and the second location will have 01 as the last 2-digits.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated (*e.g.* Professional).
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
CLIENT NAME	This group of two fields indicates the first five characters of the participant's last name and the first three characters of the participant's first name as it appears on the original claim.
MID	This field indicates the participant's unique Medicaid identification (MID) number as it appears on the original claim.
NPI	National Provider Identifier
ICN	This field indicates the unique Internal Control Number (ICN) assigned to the claim.
HVER ORIGINAL CLAIM	The header version number corresponds to the ICN and indicates the version of the claim. The original header has a version number of 00. Subsequent versions are the result of adjustments made to the header and appear in the adjustment section of the RA.
PT ACCT/RX #	This field indicates the participant account or medical record number that appears on the original claim. The prescription number is not applicable for professional claims.
MED REC #	Medical Record Number as it appears on claim.
HEADER MESSAGES	These ten fields relate to the message codes printed under the header information for the original claim. These numbers are EOB codes and indicate the reasons for payment or denial of the claim. The definitions of these codes are listed on the last page of the RA.
DNUM	The detail number corresponds to the ICN and indicates the detail of the claim.
FDOS ORIGINAL CLAIM	This field indicates the first date the service was rendered as it appears on the claim.
TDOS ORIGINAL CLAIM	This field indicates the last date the service was rendered as it appears on the claim.

Field	Description
PROC + MODS ORIGINAL CLAIM	These fields indicate the procedure code and corresponding modifiers billed by the provider for treatment of the participant. Up to four modifiers may be displayed.
QTY BLD ORIGINAL CLAIM	This field indicates the units of service as billed on the original claim.
BILLED AMT ORIGINAL CLAIM	This field indicates the amount billed on the previously adjusted claim by the provider for service.
NON ALLOWED AMT ORIGINAL CLAIM	This field indicates the non-allowed amount for the previously adjusted claim.
ALLOWED AMT	This field indicates the Medicaid allowed payment for the previously adjusted claim.
INS AMT	This field indicates the amount paid by another insurance carrier for the previously adjusted claim or detail.
COPAY AMT	This field indicates the portion of the billed amount for which the participant is responsible. Idaho Medicaid does not currently require a co-pay. This field is always 0.00.
PAID AMT	This field indicates the dollar amount originally paid.
SVC LN #	Tracking number used on professional remittance advice.
CLIENT CONT AMT	This field indicates the participant contribution amount for the previously adjusted claim.
DETAIL MESSAGES	These ten fields relate to the message codes printed under the header information. These numbers are EOB codes and indicate the reasons for payment or denial of the claim at the header level (top portion of the claim).
PREVIOUS BALANCE DUE	This field indicates the dollar amount still outstanding from the provider due to the claim adjustment performed and reported on the previous RA.
ADJUSTED AMOUNT THIS CYCLE	This field indicates the dollar amount applied toward the previous balance due for the previous claim adjustment in this payment cycle.
BALANCE DUE	This field indicates the unsatisfied dollar amount still outstanding due to the previous claim adjustment.
TOTAL REMAINING BALANCE DUE	This field indicates the total dollar amount still outstanding for all previous claim adjustments for this provider.

4.7.3 Professional Previously Adjusted Claims Paper RA Example

PROV 000078501 NPI 9988776655 IDAHO MEDICAID REMITTANCE ADVICE RA NUMBER 5545876215
SEQ NO: 1 PROFESSIONAL PAGE NUM: 6
RA DATE 11/26/2007

CLIENT NAME MID NPI ICN HVER PT ACCT/RX # MED REC#
HEADER MESSAGES
DNUM FDOS TDOS PROC + MODS QTY BLD BILLED AMT NON-ALLOWED AMT ALLOWED AMT INS AMOUNT COPAY AMT PAID AMT
SVC LN # AMT CLIENT CONT AMT
DETAILS MESSAGES

R E M A I N I N G B A L A N C E O N P R E V I O U S A D J U S T M E N T S

JACKS ULY 02554560000 9988776655 502007139238460 99 854562JAU
368
01 01/06/07 01/06/07 33870 1 3,800.00 392.10 3,407.90 0.00 0.00 3,407.90
0.00
CLAIM TOTALS: 3,800.00 392.10 3,407.90 0.00 0.00 3,407.90
0.00

PREVIOUS BALANCE DUE: -2,228.60 ADJUSTED AMOUNT THIS CYCLE: 1,100.00 REMAINING BALANCE DUE: -1,128.60

TOTAL REMAINING BALANCE DUE: -1,128.60

4.8 Professional Financial Items on a Paper RA

4.8.1 Overview

The financial items RA section contains provider financial activity for the past week. The cash control number identifying the financial transaction is displayed along with the original account, transactions applied to the account, and any balance amount. For each account, the original, transaction, and balance amounts are shown as positive amounts. Any financial transactions applied against an account are shown immediately below the account. This section is sorted by account number. Lien transactions are included in this section along with a reason code explaining the transaction.

Adjustments made to the amount in the 1099 are shown in the miscellaneous portion of the financial items. These transactions do not have an account number and the only amount shown is the transaction amount. If the adjustment increases the amount in the 1099, the transaction amount is shown as a positive amount. If the adjustment decreases the amount in the 1099, the transaction amount is shown as a negative amount.

Payouts for healthy connections case management fees and lock-in case management fees, non-claim specific payouts and claim adjustment void transactions will also display in the Financial Items section of the RA.

A grand total net financial amount is calculated to reflect the net impact of all financial items. Any financial reason codes referenced in this section are also located at the end of the section with a full description of the reason code.

4.8.2 Making Refunds to Medicaid

If a refund to Medicaid is necessary, complete an adjustment request form. A copy of this form is in *Appendix D; Forms*. Attach a copy of the original claim and a copy of the RA to the adjustment request form. Make refund checks payable to the State of Idaho, DHW, Medicaid. Adjustments may be made electronically after October 20, 2003. See *Section 2.6.1.1 Electronic Claim Void & Replacements,* for more detail about this process.

Send completed adjustment request forms and refund checks to:

EDS
PO Box 23
Boise, ID 83707

4.8.3 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of two parts. The first 7-digits are the actual unique number assigned to a provider. The last 2-digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last 2-digits, and the second location will have 01 as the last 2-digits.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated (*e.g.* Professional).
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
A/L NUM	This field indicates the number assigned to the provider's accounts ledger entry for tracking the transaction.
CCN	This field indicates the Cash Control Number (CCN) assigned by the system to the financial transaction.

Field	Description
MID	This field indicates the participant's unique Medicaid identification (MID) number, shown ONLY if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, the field will be blank. This field is also used in HMO and gatekeeper capitation payments to indicate the MID number, of the person for whom the payment is made.
NPI	National Provider Identifier
ICN	The Internal Control Number (ICN) of the claim is shown if the financial transaction is related to a specific claim. When the transaction does not relate to a specific claim, this field is blank.
HVER	The header version number indicates the header version number of the related claim, if applicable.
DNUM	This field indicates the detail number of the claim, if applicable.
TXN DATE	This field indicates the date the transaction was entered and logged in the accounts ledger.
ORIG AMT	This field indicates the original dollar amount to be withheld or paid by financial cash transactions (CCN transactions). This is the amount assigned to the accounts ledger entry to be withheld or paid.
TXN AMT	This field indicates the dollar amount corresponding to the transaction. This is the actual amount of cash changing hands (i.e. included or withheld from the payment) and applied to the original amount.
BALANCE AMOUNT	This field indicates the remaining balance to be exhausted by future financial cash transactions (amount still owed). This equals the original amount minus the transaction amount.
REASON CODE	This field indicates the reason code for the performed transaction.
NET IMPACT OF FINANCIAL ITEMS	This field indicates the net impact of all the financial items listed in the financial items section of the remittance advice. The net impact shows if the transaction will result in additions, money being paid or if the payment will be reduced.
REASON CODE	This field lists all financial reason codes referenced in the Net Impact of Financial Items section.
REASON CODE DESCRIPTION	This field describes the reason codes referenced in the Reason Code section.

4.8.4 Professional Financial Items Paper RA Example

PROV 0004125 NPI 9988776655 IDAHO MEDICAID REMITTANCE ADVICE RA NUMBER 8845621546

SEQ NO: 1 PROFESSIONAL PAGE NUM: 7

RA DATE 11/26/2007

F I N A N C I A L I T E M S

A/L NUM	CCN	MID	NPI	ICN	HVER	DNUM	TXN DATE	ORIG AMT	TXN AMT	BAL AMT	RSN CODE
752007205001000	702007205001000	0123875	9988776655	502007128131000	01	01	06/23/2007	788.45	788.45	0.00	65

MISCELLANEOUS:

NET IMPACT OF FINANCIAL ITEMS: -788.45

FINANCIAL REASON CODES
65 SUR RECOUPMENT

4.9 Professional RA Earnings Section on a Paper RA

4.9.1 Overview

The Remittance Advice Earnings section of the paper RA contains a summary of provider earnings, both current and year to date. This section includes claim counts, warrant information, and earnings data. This information is calculated per provider and is not separated by service location. A list of Explanation of Benefit (EOB) codes and descriptions, for all claims and adjustments referencing an EOB in other sections of the RA are reported in numerical order at the end of this section.

4.9.2 Field Descriptions for the Paper RA

Field	Description
PROV	This field indicates the unique number of the provider who is receiving the RA. The provider number consists of two parts. The first 7-digits are the actual unique number assigned to a provider. The last 2-digits indicate the service location. For example, if a provider has two office locations, the primary office location will have 00 as the last 2-digits, and the second location will have 01 as the last 2-digits.
NPI	National Provider Identifier
RA NUM	This field indicates the number of the RA for the provider for the current financial cycle.
RA TITLE	This field indicates the type of RA generated (*e.g.* Professional).
SEQ NO	This field indicates the RA sequence number for the provider. This field increases by one each time a provider receives an RA. The sequence number is reset at the beginning of each calendar year.
RA DATE	This field indicates the date the RA was generated. This date is typically the Monday following the financial cycle and is equal to the check issue date.
PAGE NUM	The sequence number of this page of the report when compared to the total number of pages for this report.
NUM OF PAID CLAIMS CURRENT	This field indicates the total number of paid claims processed during the past week.
NUM OF PAID CLAIMS YEAR-TO-DATE	This field indicates the total number of paid claims processed during the current calendar year.
NUM OF DENIED CLAIMS CURRENT	This field indicates the total number of denied claims processed during the past week.
NUM OF DENIED CLAIMS YEAR-TO-DATE	This field indicates the total number of denied claims processed during the current calendar year.
NUM OF PENDED CLAIMS CURRENT	This field indicates the total number of pended claims currently in the system for the provider.
NUM OF ADJUSTED CLAIMS CURRENT	This field indicates the total number of adjusted claims processed during the past week.
NUM OF ADJUSTED CLAIMS YEAR-TO-DATE	This field indicates the total number of adjusted claims processed during the current calendar year.
NUM OF VOIDED CLAIMS CURRENT	This field indicates the total number of claims voided due to claim and warrant void transactions during the past week.
NUM OF VOIDED CLAIMS YEAR-TO-DATE	This field indicates the total number of claims voided due to claim and warrant void transactions during the current calendar year.
NUM OF CASE MAIN-TENANCE FEE CLAIMS CURRENT	This field indicates the total number of case maintenance fee claims processed during the past week.
NUM OF CASE MAINTENANCE FEE CLAIMS YEAR-TO-DATE	This field indicates the total number of case maintenance fee claims processed during the current calendar year.

Field	Description
CLAIMS PAID AMT CURRENT	This field indicates the positive claims payment amount processed during the past week.
CLAIMS PAID AMT YEAR-TO-DATE	This field indicates the positive claims payment amount processed during the current calendar year. This amount equals the total of the claims paid amount fields on each RA received during the current calendar year.
CASE MAIN-TENANCE FEE PAID AMT CURRENT	This field indicates the amount paid for case maintenance fee claims during the past week.
CASE MAIN-TENANCE FEE PAID AMT YEAR-TO-DATE	This field indicates the amount paid for case maintenance fee claims during the current calendar year.
INCREASE DUE TO CLAIM ADJUSTMENTS CURRENT	This field indicates the payment increase amount processed during the past week.
INCREASE DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	This field indicates the payment increase amount processed during the current calendar year. This amount equals the total of the increase due to claim adjustments on each RA during the current calendar year.
NON-CLAIM PAYOUT AMOUNT CURRENT	This field indicates the amount paid for non-claim specific payout transactions during the past week.
NON-CLAIM PAYOUT AMOUNT YEAR-TO-DATE	This field indicates the dollar amount paid for non-claim specific payout transactions during the current calendar year. This amount equals the total of the non-claim specific payout amount fields on each RA during the current calendar year.
RECOUPMENT AMOUNT WITHHELD CURRENT	This field indicates the dollar amount withheld for recoupment transactions processed during the past week.
RECOUPMENT AMOUNT WITHHELD YEAR-TO-DATE	This field indicates the dollar amount withheld for recoupment financial transactions processed during the current calendar year. This amount equals the total of recoupment amount withheld fields on each RA for the calendar year.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS CURRENT	This field indicates the dollar amount withheld as a result of claim adjustment recoupments during the past week.
AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS YEAR-TO-DATE	This field indicates the dollar amount withheld as a result of claim adjustment recoupments during the current calendar year. This amount equals the total claim adjustment recoupment amounts on each RA for the calendar year.
LIEN, PENALTY, AND INTEREST WITHHELD CURRENT	This field indicates the dollar amount withheld as a result of lien recoupments during the past week.
LIEN, PENALTY, AND INTEREST WITHHELD YEAR-TO-DATE	This field indicates the dollar amount withheld as a result of lien recoupments during the current calendar year. This amount equals the total lien, penalty, and interest amount withheld on each RA for the calendar year.
TOTAL WARRANT PAYMENT AMOUNT CURRENT	This field indicates the total dollar amount paid for claims submitted and financial transactions processed for the past week.

Field	Description
TOTAL WARRANT PAYMENT AMOUNT YEAR-TO-DATE	This field indicates the total dollar amount paid for claims submitted and financial transactions processed during the current calendar year. This amount equals the total warrant payment amounts on each RA for the calendar year.
NET EARNINGS CURRENT	This field indicates the net earnings for the past week. It is calculated as follows: TOTAL WARRANT PAYMENT AMOUNT LIEN, PENALTY, & INTEREST + AMOUNT WITHHELD NET EARNINGS
NET EARNINGS YEAR-TO-DATE	This field indicates the net earnings for the current calendar year. This amount equals the total net earnings on each RA for the calendar year.
REFUNDS AND RETURNED WARRANTS CURRENT	This field indicates the dollar amount relating to any refund sent in by the provider, as reflected in the adjusted claims section of this RA, and voided check transactions for the past week.
REFUNDS AND RETURNED WARRANTS YEAR-TO-DATE	This field indicates the dollar amount relating to any refund and voided check transactions occurring during the current calendar year. This amount equals the total of the refunds/returned warrants on each RA for the current calendar year.
OTHER ADJUSTMENTS CURRENT	This field indicates the dollar amount of other adjustments applied to provider's earnings. It is calculated as follows: 1099 INCREASE TRANSACTION AMOUNT - 1099 DECREASE TRANSACTION AMOUNT + NON TAXABLE MANUAL PAYOUTS - TAXABLE EARNINGS - TAXABLE INTEREST PAID TO PROVIDER + TAXABLE AND NON TAXABLE INTEREST PROVIDER PAID TO MEDICAID + TAXABLE AND NON TAXABLE PENALTIES PROVIDER PAID TO MEDICAID OTHER ADJUSTMENTS
OTHER ADJUSTMENTS YEAR-TO-DATE	This field indicates the total net 1099 adjustments and manual payout amounts the provider incurred from financial transactions processed for the calendar year. This amount equals the total of the other adjustments on each RA during the current calendar year.
TOTAL TAXABLE EARNINGS CURRENT	This field indicates the net earnings for the provider for the past week.
TOTAL TAXABLE EARNINGS YEAR-TO-DATE	This field indicates the total net earnings for the current calendar year. This amount equals the total of all total taxable earnings on each RA during the current calendar year.
EOB CODES	This field contains the 3-digit EOB code. All EOB codes displayed in other sections of the RA appear here.
EOB MESSAGES	This field explains the message corresponding to the EOB code.

4.9.3 Professional Earnings Section Paper RA Example

PROV: 1544856 NPI 9988776655 IDAHO MEDICAID REMITTANCE ADVICE
RA NUM: 0544255455 PROFESSIONAL
SEQ NO: 1 RA DATE: 11/26/2007
PAGE NUM: 7

COUNTS

CURRENT	YEAR –TO-DATE
	NUM OF PAID CLAIMS
426	8,111
	NUM OF DENIED CLAIMS
21	44
	NUM OF PENDED CLAIMS
8	
	NUM OF ADJUSTED CLAIMS
10	17
	NUM OF VOIDED CLAIMS
0	0
	NUM OF CASE MAINTENANCE FEE CLAIMS
0	1,200

WARRANT DATA

	CLAIMS PAID AMOUNT
28,443.70	
	CASE MAINTENANCE FEE PAID AMOUNT
0.00	405,550.66
	INCREASE DUE TO CLAIM ADJUSTMENTS
12.60	4,200.00
	NON0CLAIM PAYOUT AMOUNT
0.00	0.00
	RECOUPMENT AMOUNT WITHHELD
-88.25	-88.25
	AMOUNT WITHHELD DUE TO CLAIM ADJUSTMENTS
-374.11	-866.35
	LIEN, PENALTY, AND INTEREST WITHHELD
0.00	0.00
	*TOTAL WARRANT PAYMENT AMOUNT
27,993.94	408,808.66

EARNINGS DATA

	NET EARNINGS (INCLUDES LIEN, PENALTY, AND INTEREST WITHHELD AMOUNT)
28,443.70	409,750.66
	REFUNDS/RETURNED WARRANTS
0.00	0.00
	OTHER ADJUSTMENTS
-449.76	-942.00
	TOTAL TAXABLE EARNINGS
27,993.94	408,808.66

*NOTE: IF TAXABLE SERVICES WERE PROVIDED YOUR ACTUAL PAYMENT AMOUNT MAY NOT MATCH THE TOTAL WARRANT PAYMENT AMOUNT.

MESSAGE CODES

365	FEE ADJUSTED TO MAXIMUM ALLOWABLE
399	PROCEDURE REQUIRES PRIOR AUTHORIZATION